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Issue Date: 26 May 2005

***In the Matter of*:**

ELLA M. LOYD,
(Widow of MOUNTIE LOYD, deceased),
Claimant, CASE NO: 2003-BLA-05713

v.

RAINBOW MINING COMPANY, INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

***Appearances*:**

Thomas M. Cole, Esq.
For the Claimant

Lois A. Kitts, Esq.
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

STATEMENT OF THE CASE

This proceeding involves a survivor's claim for benefits under the Black Lung Benefits Act, as amended, 30 U.S.C. § 901 *et seq.* ("Act"), and the regulations promulgated thereunder.[1]

[1] All references are to regulations contained in Title 20, Code of Federal Regulations, unless otherwise indicated. The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended, effective on January 19, 2001, and published at 65 Fed. Reg. 80,045-80, 107 (2000) (codified at 20 C.F.R. Parts 718, 722, 725, and 726 (2004). The Director's exhibits are denoted "D-"; Claimant's

The Black Lung Benefits Act is designed to compensate certain miners, or their eligible survivors, who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines, and who have been rendered totally disabled thereby or whose death is due to pneumoconiosis.

Because Claimant filed this application for benefits after March 31, 1980, the regulations in Part 718 apply. *Saginaw Mining Co. v. Ferda*, 879 F.2d 198, 204 (6th Cir.1989). Because the Miner last worked in the coal industry in Tennessee, the claim is governed by the law of the United States Court of Appeals for the Sixth Circuit. *See Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (en banc).

Claimant, Ella Loyd, is the widow of the Miner, Mountie Loyd. The Miner died on March 16, 2001. The death certificate, certified April 18, 2001, listed the immediate cause of death as "cardiac arrest," with an underlying cause of "acute myocardial infarction," and "hypertension" as another significant condition. (D-4). On September 6, 2001, Claimant filed for survivor's benefits under the Act. (D-3).[2] On February 18, 2003, the District Director issued a *Proposed Decision and Order–Award of Benefits–Responsible Operator*. (D-32). On April 7, 2003, this claim was referred to the Office of Administrative Law Judges for a formal hearing, which was conducted before the undersigned on April 14, 2004 in Knoxville, Tennessee.

ISSUES[3]

1. The effect of the Secretary's evidentiary limitations on the evidence proffered for this claim.

2. The length of coal mine employment.

3. Whether Claimant proved the existence of coal workers'

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exhibits, "C-"; Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr."

[2] The miner filed three claims for benefits under the Act. He lodged his first claim with the Social Security Administration (SSA) on June 16, 1972. (D-1 [D-24]). This claim was denied by the SSA, and ultimately, by the Department of Labor. The Miner filed a second claim on November 19, 1986. (D-1 [D-25]). This claim was denied, and no further action was taken by the Miner until he filed a third claim for benefits on May 8, 1997. (D-1). The Miner failed to prosecute this claim with sufficient diligence, and on December 27, 1999, the Board filed a Decision and Order affirming an administrative law judge's dismissal for failure to comply with an order to submit to a medical examination. *See* 20 §§ 725.409, 725.414, 725.465. *Loyd v. Rainbow Mining Company*, *Inc.*, BRB No. 99-0375 BLA (Dec. 27, 1999) (unpub).

[3] The employer has contested timeliness, total respiratory disability, disability causation, insurance coverage, modification, subsequent claim issues (material change) and has also challenged the Act and the Secretary's regulations. The latter issues pertaining to the validity of the Act and implementing regulations are preserved for appeal. The timeliness argument is without merit. "There is no time limit on the filing of a claim by the survivor of a miner." § 725.308(a). This survivor's claim does not entail issues of a subsequent claim at § 725.309, or modification under § 725.310. §§ 725.309, 310. Employer has not proffered evidence or presented argument about the adequacy of insurance coverage, although Employer has contested its designation as the responsible operator. The issues of total respiratory disability and disability causation are not dispositive in this survivor's claim, where the salient issue is whether the Miner's death was due to pneumoconiosis.

pneumoconiosis.

4. Whether Claimant proved the existence of complicated pneumoconiosis and invoked the irrebuttable presumption pursuant to § 718.304 that the Miner's death was due to pneumoconiosis.

5. If Claimant has established the existence of pneumoconiosis, whether that pneumoconiosis was due to the Miner's coal mine employment under § 718.203(b).

6. Whether Claimant proved that coal workers' pneumoconiosis caused, contributed to, or hastened the Miner's death.

7. Whether Rainbow Mining Company is the responsible operator.

EVIDENTIARY LIMITATIONS

The Secretary's regulations, as amended, establish certain limits on the development of medical evidence. "Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. §§ 725.414; 725.456(b)(1)." *Dempsey v. Sewell Coal Co.*, 23 B.L.R. ___, BRB Nos. 03-0615 BLA/A, slip op. 5 (June 28, 2004) (en banc), slip op. at 5. The regulations, in particular the evidentiary limitations in §§ 725.414, 725.456, 725.457 and 725.458, allow adjudicators to focus on the quality of the evidence before them. *See* 68 Fed. Reg. 69931 (Dec. 15, 2003).

The application of the evidentiary limitations cannot be waived. *See Smith*, slip op. 4-5. But, in an appropriate case, evidence in excess of the limitations in § 725.414 may be admitted upon a finding of good cause. § 725.456(b)(1).

The parties in this case have proffered evidence that exceeds the evidentiary limitations. This issue was addressed at the formal hearing, wherein the parties discussed the issue of whether a record review that is conducted by a medical expert may contain that physician's survey of medical records—specifically x-rays—that would otherwise not be admissible. Pursuant to the discussions at the hearing, the employer has submitted an "Amended Proposed ALJ Chart." The parties have submitted post-hearing briefs. Claimant has submitted a *Renewed Objection to Admission of Employer filed Documents as Evidence*.

Employer's Amended Evidence Designations

Employer submitted an amended evidence chart, dated May 13, 2004, which designated interpretations by Dr. Wiot of x-rays dated March 6, 1997 and April 15, 1997 for its affirmative case. (D-7). § 725.414(a)(3)(i). In rebuttal of x-ray interpretations offered by Claimant, Employer submitted Dr. Wiot's rereadings of x-rays taken March 22, 1996 and October 27, 2000. (E-8). Employer designated medical reports dated August 18 and August 20, 2003 by Drs. Rosenberg and Fino, respectively. (E-7, E-9). Employer also took depositions of these physicians (E-8, E-10), which are admitted under § 725.414(c). Finally, Employer designated

Dr. Wiot's interpretation of an April 27, 1997 CT scan as "other medical evidence." (D-7).

Claimant's Evidence Designations

Claimant designated x-ray interpretations by Dr. Alexander of films dated March 22, 1996 and October 27, 2000 for her affirmative case. (D-8). In rebuttal, Claimant proffered rereadings by Drs. Alexander and Baker of films dated March 6, 1997 and April 15, 1997, respectively. (C-1, C-2). Claimant offered the results of pulmonary function and arterial blood gas studies, dated March 6 and September 16, 1997. (D-6). Claimant proffered the medical reports of Drs. Alexander and Baker, who submitted their opinions based on their reviews of the Miner's medical records in reports dated August 1 and August 6, 2003, respectively. (C-1, C-8). Claimant submitted Dr. Alexander's interpretation of the CT scan dated April 29, 1997 as "other medical evidence." (C-1). Claimant also introduced hospitalization and treatment records from Dr. Perret. (D-6, C-3).[4]

Claimant's Motion to Exclude Evidence

Claimant objects to the admission of the report and deposition of Dr. Fino, designated as Employer's Exhibits 7 and 8, and the deposition of Dr. Wiot ("Proffered Exhibit 1"). She contends that the reports from Dr. Fino rely upon a number of x-rays and ventilatory studies that are inadmissible under § 725.414(a)(3)(i), which provides that:

> The responsible operator designated pursuant to Sec. 725.410 shall be entitled to obtain and submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section.

§ 725.414(a)(3)(i).

Turning to the medical report and associated deposition of Dr. Fino, I find "good cause" to admit Dr. Fino's report and deposition. Similarly, although Claimant did not renew an objection to Dr. Rosenberg's report and deposition, I find good cause exists for the inclusion of these exhibits. Further, I shall admit the medical reports from Drs. Alexander and Baker, despite references to evidence that is ostensibly inadmissible. The "good cause" determinations rest on the unique circumstances of this claim reflected in the implicit consensus among the opining doctors that assessment of change or the lack thereof in the large opacities observed in the

[4] There are medical records contained within Dr. Perret's files that include medical records from Drs. Cox, Burrell (*et al*.), and Cohen. (D-6).

Miner's lungs are indispensable to a medically valid diagnosis.[5] The salient issue is whether Mr. Loyd suffered from complicated pneumoconiosis. Resolution of that issue directly affects the determination of whether Mr. Loyd's death was due to pneumoconiosis. The various opinions opine on the nature of the lesion or mass that had been identified on x-rays and on the CT scan. Dr. Wiot, for example, had initially opined that the mass was cancerous. Other physicians, however, observed that the mass was stable over time, and therefore, was more likely complicated pneumoconiosis. Just because evidence is "relevant" does not render it admissible. However, evidence manifestly indispensable to a reliable assessment of the nature of a pulmonary condition is necessary for a fair adjudication of this claim.[6]

Claimant's motion to exclude the deposition testimony of Dr. Wiot is moot. Employer does not rely on Dr. Wiot's testimony in its amended evidence chart or post-hearing brief. (E-5, 6). Rather, Employer relies on Dr. Wiot's rereadings of x-rays and the interpretation of the CT scan dated April 29. 1997. Thus, Dr. Wiot's deposition is not part of the evidentiary record.

RESPONSIBLE OPERATOR

On August 22, 2003, the Director filed a Motion for Summary Decision on the responsible operator issue. The Director noted that, in a revised *Operator Response to Notice of Claim*, Employer effectively conceded all pertinent issues except the assertion that the Miner was last exposed to coal mine dust while working for Rainbow Mining. (D-13). The District Director established that the Miner worked for Dan Branch Mining, a predecessor of Rainbow Mining. (D-9). The Miner worked as a night watchman with Rainbow Coal, having previously worked at the belt. Dan Branch Coal, where the Miner worked between 1977 and 1979 employed Mr. Loyd on the belt. *See* §§ 725.493(b)(1), 725.495(a)(2)(ii). Thus, the Miner was last exposed to coal mine dust while working for Rainbow Mining and Rainbow Mining is the properly designated responsible operator.

LAY TESTIMONY

Claimant was unavailable to testify at the formal hearing. Claimant's daughter, Shella Hunley, testified that her father would be covered with coal mine dust when he returned from work. (Tr. 79-80). She testified that the Miner last worked in the mines about 21 or 22 years before the hearing, and except for brief interludes with non-coal mine employers, the Miner worked in coal mining as long as she could recall. (Tr. 81). She also testified that her father

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[5] I find "good cause" because this case depends on whether the stability of the lung mass identified on otherwise inadmissible x-rays and the CT scan rules out lung cancer as a viable diagnosis.

[6] Drs. Fino and Rosenberg did not directly interpret the x-rays or CT scan but reviewed the Miner's records. Their opinions as to the existence of complicated pneumoconiosis are a derivative of the opinions of Dr. Wiot.

The evidentiary limitations at § 725.414(a) exclude the medical opinions of Drs. Dahhan and Broudy. Regardless, this evidence is unduly repetitious. Administrative Procedures Act , 5 U.S.C. § 556(d) ("[T]he agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence."); s*ee generally*, *Woodward v. Director*, *OWCP*, 991 F.2d 314, 321, 17 B.L.R. 2-77 (6th Cir. 1993).

"had a bad time breathing," which was affected by any activity, and he had a cough productive of black phlegm. (Tr. at 82).

LENGTH OF COAL MINE EMPLOYMENT

The District Director determined that the Miner worked for at least 24 years in the mines. Employer has not contested that finding, which is substantially supported by the record. Thus, the Miner is credited with 24 years of coal mine employment.

MEDICAL EVIDENCE

X-Ray Evidence[7]

Exh. No.	X-ray Date Reading Date	Physician	Qualifications	Film Quality	Interpretation
C-1, C-11 D-8	03-22-96 09-10-02	Alexander	B/BCR[8]	2	1/2, q/p Cat A complicated pneumoconiosis
E-5	03-22-96 12-05-02	Wiot	B/BCR[9]	2	no pneumoconiosis; mass right hilum
C-1, C-11	03-06-97 09-10-02	Alexander	B/BCR	2	1/2, q/p Cat A complicated pneumoconiosis
D-7	03-06-97 03-26-02	Wiot	B/BCR	1	no pneumoconiosis, cancer, emphysema
C-2	04-15-97 08-08-03	Baker	B	3	1/0

[7] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "BCR".

[8] Dr. Alexander was an Assistant Professor of Radiology at the University of Maryland from 1988 to 1990. (C-9).

[9] Dr. Wiot has been Professor Emeritus of Radiology at the University of Cincinnati since 1998, and was Professor of Radiology at that university from 1966-1998. He was President of the American Board of Radiology, and the American College of Radiology, from 1982 to 1984. Although academic experience does not require that a radiologist's interpretation must be credited, *see Chaffin v. Peter Cave Coal. Co.*, 22 B.L.R. 1-294 (2003), such experience is a relevant factor. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993).

Exh. No.	X-ray Date Reading Date	Physician	Qualifications	Film Quality	Interpretation
D-7	04-15-97 03-26-02	Wiot	B/BCR	2	no pneumoconiosis, cancer, emphysema
C-1, C-11 D-8	10-27-00 09-10-02	Alexander	B/BCR	2	1/2, q/p Cat A complicated pneumoconiosis
E-7	10-27-00 12-05-02	Wiot	B/BCR	2	no pneumoconiosis; mass right hilum

Medical Reports and Opinions

Dr. Alexander

> After reviewing additional films and x-ray reports, Dr. Alexander concluded:
>
> It is clear from the dates of the above x-ray examinations that Dr. Thomas L. Cohen had the longest range perspective of Mr. Mountie Loyd, spanning the dates from 8/15/95 to 10/26/00, a period of five years and two months. Conversely, Dr. Kenneth A. Perret appears to have worked with Mr. Loyd for a period of only two months in 1997 from March until May. I would therefore favor the opinion provided by Dr. Cohen.
>
> * * *
>
> The most apparent observation to me when I reviewed this series of eight chest x-rays spanning a period of four years and seven months was the stability and consistency of the x-ray findings. It would be highly unlikely for a lung cancer, untreated, to remain stable in size for one or two years, and especially for the five-year period observed by Dr. Cohen. The unchanging stability of the x-ray abnormalities strongly makes complicated Coal Workers' Pneumoconiosis the most likely diagnosis and lung cancer the least likely diagnosis. The chest CT scan dated 4/29/97 made me aware of additional large opacities which were not convincingly apparent on the chest x-rays, and I therefore increased his complicated pneumoconiosis category from A to B.

Dr. Alexander is a board-certified radiologist and a B-reader.

Dr. Baker

Dr. Baker conducted a record review at the request of Claimant's counsel. (C-8). Based upon this review, Dr. Baker summarized:

> [T]his gentleman had x-rays over a period of 4 1/2 years that showed no change in the lesion in the right upper lobe of the lung. It would be highly unusual for cancer to not change in this period of time. With the x-ray reading by a B-reader of 1/2 and a comparison of films for over 4 1/2 years, that showed no significant change, I would strongly support this being non-cancerous and most likely the x-ray changes representing progressive massive fibrosis superimposed of Category 1/2, Coal Workers' Pneumoconiosis. As Dr. Wiot only read x-ray films taken in March and April 1997, it would be very difficult to adequately evaluate this lesion, as would the timed sequence of 4 1/2 years on the x-rays read by Dr. Alexander.
>
> In summary, this gentleman had a long history of coal dust exposure and a long history of cigarette smoking. Evidence from NIOSH researchers suggests that coal dust exposure is equally detrimental to lung function, as is cigarette smoking. This has been reported in several articles. . . . With this gentleman's severe emphysema, I would suggest, he had a significant portion of his obstructive airway disease, related to his coal dust exposure alone, much less his cigarette smoking. The x-ray changes support this finding, as well as the lack of change in the right upper lobe lesion of 4 1/2 year period of time.

(C-8). Dr. Baker is a board-certified pulmonary specialist and a B-reader.

Dr. Fino

Dr. Fino reviewed specified medical records at the request of the employer. In his August 20, 2003, report, Dr. Fino concluded:

> I do not find evidence of a coal mine dust-related pulmonary condition. The chest x-ray readings were negative, the arterial blood gases did not show resting hypoxemia, and this patient did not have persistent hypoxemia with exercise. In addition, the spirometry and the MVV values were normal, and the patient gave a good effort. In fact, there was no objective evidence of any respiratory impairment.
>
> The death certificate lists cardiac arrest and acute myocardial infarction as the cause of death. Even assuming hypothetically that this man had coal workers' pneumoconiosis and disability due to coal mine dust exposure, there is no evidence in the medical literature nor in this case that coal mine dust inhalation caused, contributed to or hastened death due to a cardiac arrest and acute myocardial infarction.
>
> * * *

> Atherosclerosis is a disease of the general medical population. Atherosclerosis and its effects on the heart are not seen in increased incidence in individuals who have worked in the mines or who had coal workers' pneumoconiosis.
>
> * * *
>
> Clearly, there is no increased incidence of coronary artery disease or its sequelae in individuals who have worked in the mines or who have coal workers' pneumoconiosis.
>
> Conclusions
>
> 1. There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.
>
> 2. There was no respiratory impairment present.
>
> 3. From a respiratory standpoint, this man was neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort.
>
> 4. Even if I were to assume that this man had coal workers' pneumoconiosis, it neither caused, contributed or hastened his death. he would have died as and when he did had he never stepped foot in the coal mines.

(E-7). Dr. Fino is board-certified in internal medicine, with a subspecialty in pulmonary disease, and is a B-reader.

Dr. Fino's deposition testimony was recorded on October 20, 2003. (E-8). He assumed a coal mine history of 40 to 44 years and a smoking history of 40 pack years. (E-8 at 8). Dr. Fino acknowledged that "[c]oal mine dust can cause obstruction, restriction, oxygen problems. There's no particular pattern of abnormality on the lung function studies that coal mine dust cannot cause a problem." *Id*. at 9. This testimony is essentially a reiteration of the conclusions reached in his medical report. Dr. Fino further explained his rationale, however:

> In order to say that coal workers' pneumoconiosis was a contributing factor in that death, which it could be hypothetically, you have to show evidence that coal workers' pneumoconiosis, on objective testing, has caused a functional impairment. On both of those planes, if you will, I don't see any objective evidence that would point to coal mine dust as causing or contributing to death.

Id. at 14-15.

On cross-examination, Dr. Fino was questioned about silicosis, and agreed with counsel's question that "the silicosis is even more subject to being latent and progressive in nature than just your plain old garden variety coal workers' pneumoconiosis." *Id*. at 19. He acknowledged that he did not read the x-rays or CT Scan, but referred instead to interpretations by others, and

conceded that with some films which may have been depicted as negative, "[t]here's no comment about the presence or absence of that condition." *Id*. at 21.

Dr. Fino was questioned about the mass that had shown up on x-rays:

> Q And I'm sure that you would agree, Dr. Fino, that if someone had a malignancy the size of a—over a centimeter in diameter and that had received no treatment for that malignancy that the chances of that malignancy staying the same size over a period of four and a half years is rather slim?
>
> A I would agree with that.
>
> * * *
>
> [I]n my opinion, a lesion that's stable over four plus years, it would be very unlikely that that would be a malignancy.

Id. at 26-27.

Dr. Fino summarized on redirect examination:

> No evidence, based on all of the information, of a coal mine dust-related pulmonary condition, either simple or complicated, either medical or legal definition, and it was my opinion that—and this is actually regardless of the presence or absence of coal workers' pneumoconiosis. Based on the information with respect to what caused his death, there is no evidence that coal mine dust played a role.

(E-8 at 33).[10]

Dr. David Rosenberg

On August 18, 2003 Dr. Rosenberg reported on his record review. (E-9). He observed:

> Mr. Loyd was 82 years of age at the time of his death, with about 44 years of coal mining employment. He was said to have had an acute myocardial infarction, leading to a cardiac arrest. A long smoking history was reported, and he had

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[10] Dr. Fino's deposition testimony, which preceded this latest report, places this conclusion in perspective:

> Again, as I looked through all of the x-ray readings, realizing that Dr. Alexander did give readings consistent with pneumoconiosis and even taking into account the CT scans, it still was quite evident to me that the overwhelming majority of the readings were either negative for pneumoconiosis or there was no mention one way or the other. And a radiologist is trained to at least–if not suggest pneumoconiosis, describe the presence of opacities, and they may not–you know, they would say "There are multiple rounded nodules in the lungs," . . . and I didn't see that.

(E-8 at 31).

severe chronic obstructive pulmonary disease based on the results of pulmonary function tests. The CAT scan of the chest demonstrated fibrocalcific changes with adenopathy, some of which was calcified. Micronodularity was not present. Also, a question was raised of a malignancy, but overall the masses apparently hadn't changed over time. Roentgenographically, he was observed to have diffuse emphysema.

Id. Dr. Rosenberg concluded:

> Based on a review of the above information, it can be appreciated that based on Mr. Loyd's CAT scan and X-ray results, there was no presence of micronodularity associated with the past inhalation of coal dust exposure; extensive emphysema was noted. While he had some large opacities, without a background of micronodularity, it would be improbable that these findings represent complicated coal workers' pneumoconiosis (CWP). Also it was noted in the records that chronic end-inspiratory rales were not noted. Clearly, the roentgenographic evidence, as summarized, did not demonstrate findings of either simple or complicated coal workers' pneumoconiosis (CWP).
>
> From a functional perspective, Mr. Loyd had severe airflow obstruction, and would have been considered disabled from a respiratory perspective. Also, he had desaturation with exercise. This disability, however, was not caused or hastened by the past inhalation of coal mine dust exposure. While there is no question that coal mine dust exposure can cause chronic obstructive pulmonary disease (COPD), when COPD occurs in association with coal dust exposure, it begins in and around the coal macule as focal emphysema develops. As the macules evolve into micronodular and then larger nodules, the underlying COPD has potential to progress in a susceptible individual. Mr. Loyd's chest x-ray demonstrated diffuse emphysema, without even findings of simple CWP. This is not the type of COPD which is associated with past coal dust exposure. Undoubtedly, his emphysema and disability related to his long smoking history.
>
> Mr. Loyd was determined to have myocardial infarction, which according to the Death Certificate, led to a cardiac arrest. A myocardial infarction represents coronary obstruction within the circulation of the heart. This is a primary cardiac event which has no bearing on the past inhalation of coal mine dust exposure. Such an event and ultimate death would not have been caused or hastened by the past inhalation of coal mine dust exposure.

Finally, Dr. Rosenberg concluded:

> [I]t can be stated with a reasonable degree of medical certainty, that Mr. Loyd's records indicate that he did not have CWP. He had postinflammatory changes (probably representing a past granulomatous infection) on his chest X-rays, which resulted in some mass formation. He also had severe smoking-related chronic obstructive pulmonary disease. His ultimate death was related to a

> cardiac event consequent to coronary artery disease which was not caused or hastened by the past inhalation of coal mine dust exposure.

(E-9).

Dr. Rosenberg gave a deposition on December 10, 2003. (E-10). He noted that the mass in Mr. Loyd's lungs had not evolved over time and opined that this stability ruled out cancer. He further explained that, as pointed out by Dr. Wiot, the Miner did not have complicated pneumoconiosis because of the absence of any background micronodularity. (E-10 at 10).

On cross-examination, Dr. Rosenberg acknowledged that he did not directly interpret the CT scan or x-rays, but instead surveyed reports of interpretations by other physicians. When asked about Dr. Wiot's March 26, 2002 report—in which Dr. Wiot opined that the Miner had an obvious malignancy—Dr. Rosenberg argued that Dr. Wiot was "not mistaken in the sense of the x-ray interpretation is correct. He did not have the advantage of seeing x-rays over time." (E-10 at 21). He also acknowledged that Dr. Wiot's report does not mention sacoidosis. *Id*. Dr. Rosenberg acknowledged that if Dr. Alexander's positive interpretations of the Miner's x-rays were correct, then the Miner had complicated pneumoconiosis. He was also asked about the death certificate's indication of a myocardial infarction and cardiac arrest, and acknowledged that the stress caused by oxygen desaturation, a phenomenon detected on clinical testing, could have been a contributing factor. *Id*. at 27. In the final analysis, Dr. Rosenberg's "analysis comes down to the x-ray interpretation and the CAT scan interpretation." He continued that "[i]f one assumes that the results as interpreted by Dr. Wiot are correct, [the Miner] doesn't have complicated CWP and his condition whatever occurred to him was not caused or hastened by coal dust exposure." *Id*.

"Treatment Notes"

Dr. Perret

Dr. Perret treated the Miner in 1997. On March 6, 1997, he wrote up a "new patient evaluation" report. He recorded a work history of 44 years of coal mine employment, and reported that Mr. Loyd had been a smoker. The Miner's complaints included a productive cough, shortness of breath with maximum exertion such as yard work, but no nocturnal dyspnea. Physical examination of the chest showed a few scattered wheezes, and the extremities showed no cyanosis, clubbing or edema.

Dr. Perret diagnosed "moderate to severe COPD by spirometry[,]" although Mr. Loyd was "relatively asymptomatic." The doctor also reported that "it appears that he has some chronic silicosis with egg shell calcification on his chest x-ray." Mr. Loyd also suffered from "poorly controlled hypertension." (C-3). The chest x-ray also revealed "what appears to be right upper lobe mass like infiltrate[.]"

On April 15, 1997, Dr. Perret reported that the Miner suffered from "moderate to severe COPD by spirometry." A chest x-ray demonstrated "a mass appearing lesion in the posterior segment of the right upper lobe." Dr. Perret thought at this time that this could be a lung cancer,

and recommended a CT Scan. Follow-up notes from May 2 elaborated the results of the CT Scan:

> We obtained CT scan of the chest after the last visit. The scan again demonstrates the egg shell calcification in the hilar and mediastinal adenopathy. He has some mediastinal lymph nodes that are borderline in size but do not have calcifications. He also has approximately 3 1/2 x 2 cm mass that is spiculated in the posterior segment of the right upper lobe. This is very suspicious for carcinoma.

(C-3). The Miner was not interested in "working up" the lung mass. Dr. Perret, while suspicious that the mass was cancer, also thought that "egg shell calcifications" that had showed up on x-rays were related to Mr. Loyd's coal mine dust exposure. A chest x-ray appeared to be "relatively unchanged" from the prior film. Dr. Perret is board-certified in internal medicine, with subspecialties in critical care medicine and pulmonary diseases. (C-10).

Dr. Perret submitted a letter dated September 16, 1997. (C-12; D-5). In the letter, he referenced the Miner's arterial blood gas and ventilatory testing and the soft tissue mass in the Miner's right infra-hilar area. He concluded:

> Given the fact that the patient has an x-ray consistent with dust exposure, spirometry that showed significant obstructive lung disease, evidence of oxygen desaturation with exercise, a history consistent with significant dust exposure, and daily symptoms of sputum production and shortness of breath, I think it would be reasonable to re-assess Mr. Loyd's claim for black lung benefits.

Dr. Cohen

Dr. Cohen interpreted a series of x-rays, the results of which were not classified under the ILO system. (C-5). He reported that the film taken on October 26, 2000 revealed:

> Thoracic aortic atherosclerosis. Chronic obstructive pulmonary disease. Marked post inflammatory pulmonary changes, including healed calcific granulomatous pulmonary disease. No acute abnormality or significant change since 10/28/99.

Similarly, the October 28, 1999, January 17, 1998, November 9, 1996, July 30, 1996 and March 22, 1996 films revealed essentially the same abnormalities. In his interpretation of the July 30, 1996 film, Dr. Cohen noted with respect to the "non-specific right hilar prominence, unchanged since 3/22/96":

> Although this lack of change favors benign disease, if old chest films (prior to March, 1996) can not be made available to confirm the chronicity of the right hilar prominence, and if clinically warranted, additional diagnostic work up would be necessary to exclude the possibility of significant neoplastic disease.

> The first film available to Dr. Cohen was dated August 15, 1995. He noted:

> Abnormal right-sided density, as noted above, cause undetermined. Most likely possibilities would be chronic scarring and/or fibrosis (e.g. secondary to pneumoconiosis, if applicable), acute or chronic pneumonitis with associated segmental atelectasis or malignant pulmonary neoplasm.

(C-5). Dr. Cohen is board-certified in radiology. (C-6).

CT Scan

Dr. Cox interpreted a CT scan of the chest dated April 29, 1997. (C-4). His findings included "a 2.5 to 3 cm soft tissue density mass with rather marked spiculated margins in the right infrahilar area." Dr. Cox provided the following impression:

> Fibroreactive changes with evidence of prior inflammatory process or infection with diffuse mediastinal and hilar lymph node calcifications. Differential considerations include history of pneumoconiosis, silicosis, sarcoidosis, fungal infections. . . The soft tissue density mass with spiculated margins in the right infrahilar area could represent a conglomerate area of fibrosis, however a neoplastic process will give the same radiographic appearance. Further evaluation of this spiculated mass is recommended.

(C-4). Dr. Cox is board-certified in radiology. (C-7)

Dr. Wiot

> Dr. Wiot interpreted the CT scan on March 26, 2002. (D-7). He concluded:
>
> These findings have all the characteristics of a malignancy. There is old granulomatous disease in the left upper lobe with associated pleural thickening. Of concern is a questionable mass also present on the left, again having the characteristics of a malignancy, which is much smaller than the mass on the right, but in the same general area.
>
> In summary, this patient shows no evidence of coal worker's pneumoconiosis by chest x-ray or by CT. This patient has severe emphysema and an obvious malignancy on the right, and probably a secondary malignancy on the left as well.

(D-7).

Dr. Alexander

Dr. Alexander is a board-certified radiologist with specialties in diagnostic and nuclear radiology, and a B-reader. (C-9). In addition to reading various x-rays, he interpreted the CT Scan. (C- 1). He concluded:

> There is a background of small round and occasional irregular opacities in the mid and upper lung zones consistent with Coal Workers Pneumoconiosis. Although the chest x-rays show hyperinflation, no focal emphysematous changes or bullae are seen on the CT scan. There are densely calcified bilateral hilar lymph nodes, many of which have an eggshell configuration typical of silicosis. Multiple large opacities greater than 10mm in size are present. Images #5-7 demonstrate a 15mm conglomerate mass in the posterior segment of the left upper lobe. Images #8-14 demonstrate a 50 x 30mm conglomerate mass in the posterior right upper lobe extending into the right hilum. Images #12-14 demonstrate a 30mm conglomerate mass in the posterior left upper lobe. The summed diameters of these masses exceeds 50mm, but is less than the equivalent area of the right upper zone, thereby indicating category B complicated Coal Worker's Pneumoconiosis according to the 1980 ILO classification system. The chest CT scan dated 4/29/97 made me aware of additional large opacities which were not convincingly apparent on the chest x-rays, and I therefore increased his complicated pneumoconiosis category from A to B.

(C-1, C-11).

DISCUSSION

Because this claim was filed after April 1, 1980, it is governed by the regulations at Part 718. Under § 718.205, where there is no miner's claim filed prior to January 1, 1982 resulting in entitlement to benefits, a survivor who files a claim after January 1, 1982, as in this case, is entitled to benefits only upon demonstrating that the miner died due to pneumoconiosis. Specifically, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) the miner suffered from pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and (3) he died due to pneumoconiosis. *See Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986) (en banc). Evidence in equipoise is insufficient to sustain Claimant's burden. *Director, OWCP v. Greenwich Collieries, et al.*, 512 U.S. 267 (1994).

The provisions at § 718.205 require competent medical evidence, which (1) establishes that the miner died due to pneumoconiosis; or (2) that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of § 718.304 is applicable. Pneumoconiosis constitutes a "substantially contributing cause" if it serves to hasten death in any way. § 718.205(c)(5); s*ee Brown v. Rock Creek Mining*, 996 F.2d 812, 815 (6th Cir. 1993). However, the standard is not satisfied if pneumoconiosis contributed to the miner's death to a "negligible" degree. *See Grizzle v. Pickands Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993).

Complicated Pneumoconiosis

As noted above, the dispositive issue in this case is whether the Miner suffered from complicated pneumoconiosis. In order to invoke the irrebuttable presumption that a miner's death was due to complicated pneumoconiosis, a survivor may introduce, *inter alia*, "x-ray evidence of opacities greater than one centimeter in diameter ... or other medical evidence analogous to such opacities or lesions." *Gray v. SLC Coal Company*, 176 F.3d 382, 387, 21

B.L.R. 2-615 (6th Cir. 1999). § 718.304. Section 718.304 establishes an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from a chronic dust disease of the lung and (a) has radiological evidence of a large opacity greater than 1 centimeter in diameter, (b) a biopsy or autopsy yields massive lesions, or (c) would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) had the diagnosis been made as therein described provided that any diagnosis accords with acceptable medical procedures. § 718.304. Section 718.304 requires this tribunal to weigh the evidence from each category together before invoking the presumption. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (en banc).

Section 718.304(a)

There are eight interpretations of four chest x-rays that have been designated by the parties. Dr. Baker read one film, taken on April 15, 1997, as positive for simple pneumoconiosis. (C-2). Dr. Alexander has read three films as showing, *inter alia*, Category A complicated pneumoconiosis. His interpretations are contrary to those of Dr. Wiot, who has read all four films as negative for pneumoconiosis. Dr. Wiot's x-ray reports have viewed the large opacity as cancer. Taking this evidence alone, I find that the x-ray evidence is in equipoise, and find that Claimant has not demonstrated complicated pneumoconiosis at § 718.304(a) by a preponderance of the evidence. The interpretations by Dr. Wiot, however, do not rule out the presence of complicated pneumoconiosis.

Section 718.304(b)

Because there is no autopsy or biopsy evidence, the Claimant can not prove complicated pneumoconiosis under § 718.304(b).

Section 718.304(c)

Upon review of all relevant evidence under § 718.204(c), I find that Claimant has demonstrated the existence of complicated pneumoconiosis. I have evaluated the hospital/treatment notes, the medical opinions and depositions from Drs. Fino and Rosenberg, and the CT-scan interpretation of record, as well as the x-ray evidence.

The concern about the presence of cancer was voiced by Dr. Perret, who concluded on May 2, 1997 that the mass was "very suspicious for carcinoma." (C-3). He also identified "egg shell calcifications" that he associated with the Miner's exposure to coal mine dust. The notes from the Miner's long-term consultations with Dr. Cohen show that Dr. Cohen, a board-certified radiologist, observed that the "abnormal" density had not changed over time, and suggested the possibility of fibrosis, pneumonitis or "malignant pulmonary neoplasm." The most probative evidence, however, is the various interpretations of the CT scan. Neither Dr. Fino nor Dr. Rosenberg, although both are B-readers, read the CT scan directly.

Dr. Cox initially read this scan, and his interpretation in 1997 suggested a range of possible explanations for the "density mass." There was no conclusive diagnosis, and Dr. Cox suggested further evaluation. Dr. Wiot read the results of this scan and opined that the mass in

the upper right lung was an obvious malignancy, with a "questionable mass" in the left portion of the lung that was probably a secondary malignancy. (D-7). The most detailed explanation of this mass is provided by Dr. Alexander's review of the CT scan in his August 1, 2003, report. His conclusions recognize the stability of the density–a factor that weighs against a diagnosis of cancer. Dr. Alexander also identified eggshell type silicosis and noted a conglomerate density in the left lobe. The extensive explanation accompanying his findings, as well as his recognition of the stable nature of the mass and of the eggshell calcifications, is persuasive evidence of complicated pneumoconiosis and not of cancer or sarcoidosis.

In assessing the probative value of these conflicting CT scan opinions, I have accounted for "the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269 (4th Cir. 1997). *Accord*, *Underwood v. Elkay Mining, Inc*., 105 F.3d 946, 950-951, 21 BLR 2-23 (4th Cir. 1997). Dr. Wiot possesses impressive credentials both as a pioneer in this field and in academia. *See Worhach v. Director*, *OWCP*, 17 B.L.R. 1-105 (1993). However, a tribunal is not compelled to credit an academic radiologist. *See Chaffin v. Peter Cave Coal. Co.*, 22 B.L.R. 1-294 (2003). Dr. Alexander's detailed explanation, as well as his recognition of the stability of the mass over time, against the corroborative background of a preponderance of other medical opinions of record, endows his interpretation of this crucial test with preponderant probative value.

Upon review of *all* relevant evidence under § 718.304, I find that complicated pneumoconiosis has been established. Although I have found that the x-ray evidence alone did not demonstrate the existence of complicated pneumoconiosis at § 718.304(a), this finding does not undermine and, indeed, is not inconsistent with, the proof of the disease on the basis of the CT scan. The x-rays demonstrate the existence of a mass greater than one centimeter in the right lung. Although the chest x-ray evidence does not establish the presence of complicated pneumoconiosis, that evidence, considered in concert with the CT scan interpretations, supports a finding of complicated pneumoconiosis because of the substantial and convincing evidence of opacities greater than one centimeter, consistent with the x-ray evidence. The CT scan provides a more probative identification of the disease process than the x-rays. I am most persuaded by the opinions of Dr. Alexander, who identified this mass as complicated pneumoconiosis rather than a malignant lesion. His diagnosis is buttressed by his identification of eggshell calcifications and his recognition that they are typical of silicosis—which is consistent with pneumoconiosis. Dr. Rosenberg's and Dr. Fino's assessments, being dependent upon Dr. Wiot's interpretation of the CT scan are unpersuasive and inconsistent with the preponderance of the evidence, particularly the direct interpretation by Dr. Alexander. Dr. Wiot's interpretations of the x-rays and the CT scan have clearly been impeached.

CAUSALITY

Section 718.203(b) allows a presumption that a miner's pneumoconiosis arose out of his coal mine employment where the miner had worked at least ten years in the mines. Because the Miner worked in the coal mines for at least 21 years and the inference of causal relationship is not rebutted, his complicated pneumoconiosis is deemed to have arisen from his coal mine employment. § 718.203(b).

CONCLUSION

I therefore find that Claimant has proved the existence of complicated pneumoconiosis in the Miner. Death is considered due to pneumoconiosis "[w]here the presumption set forth at § 7128.304 is applicable." § 718.205(c)(3). Because I find that the Miner had complicated pneumoconiosis, the § 718.304 presumption applies and I find that the Miner's death was due to pneumoconiosis.

ORDER

The claim of Ella M. Loyd for survivor's benefits under the Act is granted. [11]

Accordingly, Rainbow Mining Company, Inc., shall:

1. Pay Ella M. Loyd all benefits to which she is entitled under the Act, commencing March 1, 2001 pursuant to § 725.503(c).

2. Reimburse the Secretary of Labor for any payments made to Claimant, if any, and deduct such amounts from those ordered pursuant to Paragraph 1.

3. Pay Claimant or the Secretary of Labor, as appropriate, interest at the rate applicable under § 725.608.

4. Pay Claimant's attorney, Thomas M. Cole, Esq., fees and expenses as approved in a Supplemental Decision and Order.

A

Edward Terhune Miller
Administrative Law Judge

Washington, D.C.

[11] Thirty days is allowed to Claimant's counsel for submission of an application for attorney's fees. The application is governed by §§ 725.365 and 366. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten (10) days following receipt of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.